IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION
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MARY JANE BOERNER and HENRY. W. BOERNER, Her Husband,	)	
Plaintiffs,	)	
vs.	)	No. LR-C-98-427
BROWN & WILLIAMSON TOBACCO CORPORATION, et al.,	)	
Defendants.	)	

DEPOSITION OF MARTIN BLINDER, M.D.

Monday, December 13, 1999

LEEDY & ASSOCIATES
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Reported by:
ANASTASIA ROCKWELL, CSR 4385 (CA)

I N D E X

BE IT REMEMBERED THAT pursuant to Notice of Taking Deposition and on Monday, the 13th day of December, 1999, commencing at the hour of 10:00 o'clock a.m. thereof, at the Offices of Martin Blinder, M.D., 130 Melville, San Anselmo, California, before me, ANASTASIA ROCKWELL, a Certified Shorthand Reporter of the State of California, personally appeared

MARTIN BLINDER, M.D.,

an expert witness herein, who, being by me first duly sworn, testified as is hereinafter set forth.

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GARY EUBANKS & ASSOCIATES, 708 West Second Street, Little Rock, Arkansas 72201, represented by JAMES GERARD SCHULZE, Attorney at Law, appeared as counsel on behalf of the Plaintiffs Mary Jane and Henry Boerner.

CHADBOURNE & PARKE, LLP, 30 Rockefeller Plaza, New York, New York 10112, represented by BRUCE G. SHEFFLER, Attorney at Law, appeared as counsel on behalf of the Defendants Brown & Williamson Tobacco Company.

DINSMORE & SHOHL, LLP, 1900 Chemed Center, 255 Fifth Street, Cincinnati, Ohio 45202, represented by FRANK C. WOODSIDE, Attorney at Law, appeared as counsel for Defendants Brown & Williamson Tobacco Company.

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EXAMINATION BY MR. SHEFFLER

MR. SHEFFLER: Just before we get started, I have the exhibits to the first deposition if there is anything you need.

THE WITNESS: I don't need the exhibits. I just want to change the depo.

MR. SHEFFLER: Before we do that, Doctor, this is the continuation of the deposition we began in August and you did get a copy of that deposition I see?

A. Yes.

Q. And you have reviewed it and you have some changes you want to make?

A. Please.

Q. Before we get to that, can I just ask you a couple of questions. Did you talk to anyone about the deposition before today?

A. I talked to Mr. Schulze last night. We talked about it a little bit.

Q. Anyone else?

A. No.

Q. What did you and Mr. Schulze discuss about the deposition?

A. He read a few sections from it. I can't remember which they were.

Nothing of substance transpired. He made a

comment or two about the questions and the answers. Essentially commended the way it went.

The changes I am about to suggest have nothing whatever to do with our conversation. It wasn't a substantive conversation, really.

Q. Can you tell us what the subject matter of the sections he read to you was about?

A. He read about six or seven sections equally distributed throughout. There is no common theme. We spent about an hour and a half talking.

Q. You can't recall anything?

A. Nothing dramatic occurred. Certainly not about the deposition and we spent relatively little time about that. Most of the time was spent on other matters.

Q. What other matters?

A. He went through the text. We looked at some graphs in here, some sections in the chapters.

Q. You are referring to?

A. This is Nicotine Addiction by Orleans and Slade. We talked, for example, about the epidemic of lung cancer hitting in the 1940's and '50's, some 20 or 30 years after smoking became fashionable.

We talked about the difference in smoking rates amongst blue and white collar type people.

We talked about the decedent's addictive history

and how that fit the generic pattern of smoking.

We talked about what I felt would be the thrust of my testimony perhaps here, certainly at trial, as opposed to the roads we traveled in response to your questions, what I thought the direct examination would be which did not always comport with what I found myself talking about at length because I was responding to your inquiry.

We talked about where Mr. Schulze might be going for dinner last night.

Q. I am not too interested in the last point. What is the thrust of your testimony which differed from my inquiry of you last time?

A. I think it was in part a matter of emphasis and willy-nilly hither and yon you did pick up elements of it. But if I were simply allowed to say what it is that I have come to say, I would talk to the jury in terms of what addiction actually is. And that the definition that I find most useful is certainly not in conflict with the tripartite definition in DSM-IV or the nine part definition in the Surgeon General's report but emphasize what I consider to be the salient element which is that an addictive substance is an unnatural substance, a substance that does not occur naturally in the body nor during the natural course of one's day that enables the addict to

feel normal. Or, looking at the other side of the coin, an addictive substance is an unnatural substance the absence of which now leaves the addict feeling distinctly abnormal so that after an hour or two or three the smoker has to smoke in order to feel the way they used to feel before they ever discovered tobacco, in order to feel the way non-smokers feel all the time and of course there is some variety. We all have good days and bad. But what tobacco does is enable the addict to achieve baseline psychological and physiological levels of comfort.

This clearly puts tobacco with the other common addictive substances like heroine and cocaine and the definition clearly distinguishes it from compulsive over eating and exercise and some of the other substances which you tobacco lawyers typically attempt to put in the same group so as to trivialize the malignancy of this addiction.

Q. Strike that comment but go ahead.

A. I would also like to talk to the jury about diabolical techniques the industry has used for the past five decades which I continue to see at trial and in the transcripts I have read where you use clever language to obfuscate and confound the issues. You do that at trial in order to achieve an outcome which I believe to be at war with the clinical facts, clinical facts being that

tobacco causes cancer. It kills. It is not a risk factor. It kills. And that it is addictive and that the industry bears the brunt of responsibility for the smoker being addicted, not all of it but the brunt of it.

Somehow these salient facts get lost in all of the techniques that you folks so skilfully use and which the industry has used. For example, you manage to get witnesses to use your language and the industry has created a mind set amongst smokers that smoking is pleasurable, people enjoy smoking. You enjoy smoking or Mrs. Brown enjoyed smoking, did she not. You get people nodding their head, smoking addicts have this rationalization they are not addicted, they just enjoy smoking. Very clever.

It is not enjoyment. What the smoker experiences after they light up following a two or three hour period of abstinence is that restoration of normality or the warding off of the early symptoms of withdrawal. I expect in a sense that's enjoyable. If I hit you on the head with the hammer for ten minutes, when I stop doing it, that would be relatively pleasurable.

Not quite recently the industry foisted upon smokers the notion that they merely had a habit. And until the last trial or two, that canard continued to be utilized in the court. Well, it is not a habit and I

think I talked in my deposition last time about what habit is. Habit is buttoning your shirt from the bottom up or the top down, brushing your teeth in the morning, the perfunctory kiss on your spouse's cheek as you go out the door. Those are habits. Smoking is an addiction.

You and the industry for years have talked about choosing to smoke or choosing to quit. "She decided to quit or she decided she enjoyed it so she wouldn't quit." And, again, you get your lay witnesses sort of nodding the heads as if that's all that's going on and that's another bit of deception.

Addicts are not overly without free choice but there are a variety of things that happen. Some psychological some physiological that vitiate their free choice, their ability to choose, their ability to decide. And I think that you have used techniques as have the industry to obfuscate that fact.

Q. Did you mean me personally --

A. You are a tobacco lawyer. And you are an agent of a sociopathic industry.

Q. Do you think I am a sociopath as well?

A. You are an agent of a sociopathic industry.

Q. So you would view me as sociopathic at least insofar as I try to carry out the desires of that industry. Is that right?

A. I think you are going to have to make peace with that concept or not. It is not for me to say. I am not here to engage in character assassination.

I will say what I want to say is that you are an agent of a sociopathic industry.

Q. Do you think people who work for that industry are sociopaths?

A. I think the secretary who comes to work everyday and types letters --

Q. How about the CEO. Is he a sociopath? Are board of directors sociopaths?

A. It brings me to my next point which is this issue of why don't the smokers respond to the warnings and --

Q. Before you get to that, I want to get that differently. I want to spend some time on that issue. That's an important issue. But I would like to get an answer my question here.

A. I am going to. My next point goes specifically to your question. Trust me. It will be responsive.

We talked last time about selective inattention and how it is the nature of the addict not to respond to what a nonsmoker would certainly say is a clear admonition finally that smoking can cause cancer. Smokers see that warning; they see the newspaper articles. They hear radio

broadcasts but it doesn't appear to register. And this is a quality that if not unique to addicts is certainly characteristic of them where they, in order to remain congruent with their conduct, they have to disassociate with compelling data that would be in conflict with their behavior. It doesn't register. Bear with me one more minute.

Q. Don't forget the question you are answering.

A. Oh, no.

I would challenge anyone in this realm to tell me what letters go with what numbers on the telephone key pad even though you see it several hours everyday for years. It just doesn't register. Awhile back I went through a stop sign at an intersection with which I am quite familiar. My mind was on something else but it didn't register until the policeman kindly called it to my attention. And it wasn't a California stop. I went through it 35 miles per hour. It didn't register.

The ultimate affect of your success as an attorney in this litigation is to enable the tobacco industries to continue to prosper and, therefore, to continue to kill Americans. I don't think that factor naturally registers you with. You are sitting here taking the deposition of the psychiatrist and he is an adverse witness and you are trying to try to chip away at what he

does. You are not really thinking of the people that your client kills. That your client is a serial killer. That ability to isolate and sequester certain aspects of what it is you are doing enable you to continue to do this.

When you went to law school, you never thought you would be acting in the service of killing Americans. That's what you are doing. You can't think in those terms and get up in the morning and go to work. So the mind does very interesting things in how it sequesters and suppresses and disassociates certain aspects. And that is what I believe the CEOs do.

Now does that make them or you sociopathic? I am not prepared to get into that philosophical discussion. But the industry is sociopathic. Even though there are people who work for the industry that I think are probably wonderful people. They say Adolf Hitler loved dogs and children. You can be different things at different times. Does that answer your question?

Q. Well, let me ask a follow up and I might get the answer.

When you say the industry is a sociopathic industry, you understand that the industry is made up of a number of tobacco companies?

A. Yes.

Q. You understand those companies act through

individuals, correct?
A. Yes.
Q. You understand that they have a board of directors?
A. Yes.
Q. You understand there is a corporate chairman, CEO, chairman of finance, all of the different corporate structure that you have in any industry?
A. Right.
Q. Do you understand for each of those companies the company can only act through people?
A. Yes.
Q. And you understand that there are shareholders for these companies as well?
A. Right.
Q. You are calling all those people sociopathic?
A. No. I didn't call any person sociopathic.
Q. When you say the industry, since the industry is nothing other than people --
A. Industry is a legal person. It is a corporation.
Q. Take that away. Put that aside for a moment. We are not talking about --
A. I am.
Q. What we are talking about is reality.

A. I am saying that the industry is a corporate person and that corporate person is sociopathic. Do the individuals who make up the business, are they individually sociopathic, certainly not.

An analogy. The Nazi movement and its destruction of the Jews was clearly a psychopathic process. Hitler was a sociopath and so were his agents. The people who gave the Nazi movement its thrust, its philosophy were profoundly sociopathic. But the individual soldiers who marched into Belgium, there were good guys and bad guys as there are on both sides. So it is possible though individuals through this disassociation mechanism to be agents of a sociopathic movement.

Q. I did ask you some open ended narrative questions and you did give me some open ended answers. It is helpful, though, if you let me ask you specifically questions that deal with this case now because I understand that you want to talk about Mrs. Boerner as well as your general ideas about addiction.

In the last deposition we had you gave us a definition -- your definition of addiction had eight factors. We will go over those again in a minute. You have summed it up a little bit here by saying it is an unnatural substance that allows the addict to feel normal or in the absence of which makes the addict feel abnormal.

A. Right.
Q. We have a lot of time.
And then you went on to say talk about Mrs. Boerner.
Did Mrs. Boerner use tobacco or nicotine to feel normal?
A. You are asking me that?
Q. Yes.
A. My answer would be yes.
Q. Did Mrs. Boerner enjoy smoking?
A. I have told you that that use of the word enjoy is a trick. She would say that she did. She did.
Q. Let me ask you as I did at the last deposition, tell me if you retract your testimony or not.
You say Mrs. Boerner enjoyed smoking in your report?
A. Yes.
Q. That's what she said.
"Question: She said, 'I enjoy smoking.'"
"Answer: Yes.
"Question: Did you explore that?
"Answer: Yes, I did.
"Question: What did she say she liked about it?
Answer: This is a tricky question because it is very difficult to distinguish between people who, quote,

"are having pleasure from something," end quote, "as distinguished from their avoiding the distinct disphoria that results when they don't have something. And I really try to focus in on that.

"Was she really enjoying it, or was this a euphemism for saying she didn't enjoy how it felt when she didn't smoke. I cannot say that I was successful in that endeavor."

Are you changing that testimony?

A. Not at all.

Q. Did you learn something new to say that Mrs. Boerner did not enjoy smoking when she was smoking?

A. No. I retain the distinction that we have made throughout our inquiry, our dialogue.

Q. Did you --

A. Wait.

Q. Sorry.

A. Got to listen carefully to my sentence before you put a period.

I maintain the distinction that you and I have tried to make through our dialogue that there are certain things we know generically about smoking addiction and the group of people who smoke versus what you can learn about a specific individual. There are certain things that are not necessarily noble for the individual yet we can say to

a reasonable degree of medical probability are noble about the group.

I could not use Mrs. Boerner to illustrate what I believe to be a generic maxim which is that when smokers talk about enjoying something, what they really mean is they are warding off the early incipient feelings of withdrawal. I could not use Mrs. Boerner to illustrate that and I have to be candid you with when I failed. It doesn't change my conviction, however, that the sociopathic industry has given people this mind set.

Q. You can, Doctor, continue if you wish but it is going to prolong the deposition. I am not interested in your feelings any longer about me, the tobacco industry, whether it is diabolical or not. It is not in the scope of your testimony as we agreed in the deposition and I will move to strike it if you continue to talk about it.

A. You can strike it if you want. As far as I am concerned, whatever the lawyers agreed to that is within the scope of my testimony, you are entitled to know today.

Q. I do know.

A. What I plan to say if I get the chance, and maybe you will get it struck in court, but certainly I think the jury deserves to hear what it is you folks do, and I am going to do what I can to see that they hear it.

Q. Are you retracting your testimony that it helped

her concentrate, nicotine, smoking?
A. No.
Q. Are you retracting your testimony that it helped her relax in times of stress?
A. No.
Q. Are you retracting your testimony that she did not enjoy smoking less in 1981 than she did in 1975?
A. No, I am not retracting any of that. I am adding to it that her use of the word enjoy is suspect for reasons given and that her feeling that she concentrates better or that it helps her cope with stress is a restoration of normal mechanisms and normal ways of feeling she would have enjoyed had she never discovered smoking. That's what I am adding to my testimony. That's what I wanted to clean up with you.
Q. And that is based upon not her specifically but generic smokers?
A. Yes.
Q. And you would rely upon the empirical evidence in the medical literature that looked at, with the use of control groups, what happened when people quit smoking in terms of whether or not they get the baseline effects?
A. I would look at that. I'm not sure I would rely on it.
Q. You would rely upon your clinical views rather

than empirical evidence?
A. Because I am suspicious of statistical studies. You can design a study to show anything you want and I think again the tobacco industry has cleverly used studies in a way of perverting the essential clinical trial. When I hear the word study, the back of my hair goes up. This is not to say that I don't read studies. I have an open mind but it is a skeptical open mind.
Q. Move to strike. That's fine.
You mentioned that tobacco industry used decided to quit as a euphemism for choice or voluntary behavior?
A. Synonym.
Q. Did Mrs. Boerner decide to quit smoking at any point in her life?
A. Yes.
Q. Did she decide to quit smoking in 1981?
A. Yes.
Q. Did she make a serious attempt to quit smoking in 1981?
A. Yes.
Q. You did say, Doctor, and I want to get to this that you had some materials that you got from Mr. Schulze or at least you got a letter from him?
A. I got materials.
Q. You got materials and a letter. Can you give me

a description of what you got?
A. It is a three line letter saying here are the depositions of Henry Boerner and Lloyd Scoggins. I am certain that Mr. Sheffler will question you about these and then the depositions themselves.
Q. Is there anything else -- what was the date of that letter?
A. 12/1/99.
Q. Was there anything else that you received from Mr. Schulze?
A. No. I received my deposition.
Q. Did you receive a letter from him of the 23rd of September. Is that right? Did you receive a letter from him dated September 23rd that you responded to?
A. I guess so. I see, "Thank you for yours of September 23."
Q. Do you have that?
A. No.
Q. Could you recall for us what he sent you?
A. No.
Q. What did the letter say?
A. I can only reconstruct it from my answers. I have no recollection of the letter itself.
MR. SHEFFLER: Gerry, what did you send him in the letter?

MR. SCHULZE: I don't remember. I can go find it.

MR. SHEFFLER: It is not important at this point.

Q. But then you wrote to Mr. Schulze and you --

A. Yes.

Q. And you basically -- two page letter?

A. Page and a half, yes, sir.

Q. Was there anything you sent with the letter?

A. I don't believe I did, no.

Q. Did Mr. Schulze give you anything further or tell you anything further about this letter that you wrote dated September 24? Did he describe to you how he used it or would use it or anything else?

A. In our evening meeting yesterday, we talked about the warning issue and seems to me that this goes to that topic.

Q. What's the warning issue?

A. You will forgive me if I misstate but apparently one of the questions is the degree to which the tobacco company might have admonished its customers but failed to do so. Would there have been warnings that might have spared Mrs. Boerner's life.

Q. Anything else? What was discussed about that issue?

A. I think along the lines of my letter and what in fact, I may have said at the first deposition which is that no warning comes with an absolute warranty but some warnings are better than others and that how I fault the industry --

Q. Doctor, not interested in that.

A. Whether you are interested or not, I am going to finish my sentence.

I fault the industry less in the warnings themselves which I take issue with as a psychiatrist and looking at the psychological effects on their intended percipient but more on all of the other things the tobacco industry was doing at the same time to vitiate those very warnings. That's what we talked about.

Q. Move to strike the last part of the answer.

A. You shouldn't have asked me what we talked about. That's what we talked about.

MR. SCHULZE: This is just a discovery deposition. Dr. Blinder is going to be at trial as I understand it. I just want to make sure that we are all clear on that.

MR. SHEFFLER: Absolutely. But I also want to make clear under the federal rules this deposition can be used for any purpose I want to use it for and I will probably use it.

MR. SCHULZE: I am sure you will.
MR. SHEFFLER: Q. You had spent about 20 hours the last time we talked on this case with your additional work. How much have you spent now or additionally how many hours have you spent now?
A. I spent an hour and a half with Mr. Schulze. I spent about an hour reading my words of August. And couple of hours reading the family depositions.
Q. Your words of August being the --
A. The first part of this deposition.
Q. And the family members being Mr. Boerner, Mr. Scoggins that were recently taken?
A. Yes.
Q. Tell me the things that you want to change in your deposition or amend or whatever you want to do.
A. On page 102, line eight. You asked if I were a member of any professional, quasi professional organizations and I said no.
Q. Other than what you had listed in your CV?
A. Yes. And I since remembered that I have long been a member of Group Against Smoking Pollution, GASP and ASH.
Q. A-S-H is ASH?
A. Yes.
Q. So you would change both your answers to include

those.

And then the next question where it asked have you ever contributed or become a member -- have you ever contributed or become a member to any organization whose goal is to reduce cigarette consumption or smoking in society. And you would list GASP and ASH --

A. Yes.

Q. -- to that question?

A. Yes.

Q. Which you forgot about?

A. I forgot about. I have contributed to them financially and my brain power.

Q. When you say contributed with your brain power, have you given any seminars to this group?

A. No.

Q. Have you written anything for them?

A. I have sent letters at their suggestion, yes.

Q. To who?

A. Congressmen, senators.

Q. How long has this been going on?

A. 20 years.

Q. You have been sending letters to congressmen and senators for 20 years?

A. Probably the first one went out 20 years ago. I don't do this on a regular basis but I have on occasion.

Q. Do you have any copies of those letters?
A. No.
Q. They would be proselytizing your views about the addictive nature of nicotine and tobacco?
A. I can't tell you at this point what the content of the letters were but they are probably not favorable to the industry.
Q. Would they deal with your advice about nicotine addiction?
A. If I could remember what they said, I would tell you. I have no recollection. That's entirely reasonable.
Q. Next.
A. At the bottom of page 180 you asked me, what a sine qua non of addiction might be in my view. And during the course of the next 10 or 12 pages, you got a melange of responses which included the one that I just highlighted for you. Restores a sense of normality, that's in there. But it didn't come to follow your question about the sine qua non. If I could live that deposition over again, that would be a good place to put it rather than two pages later.
At the bottom of page 231, line 20, a word got dropped. There are typos all over but this is one I probably should correct. The word was dropped. At that point God intervened."

Q. I understood that.
A. I think that's what I have.
Q. We do have the videotape.
A. I am not going to go over any typos.
Q. There is quite a few of those things we need to change.
A. I think that will hold me. I can live with the rest.
Q. Let me just point to you 298 if I could for a second.
A. Got it.
Q. That's the wrong page. It is really page 291. There is an answer on 291 that basically talks about addiction. It gives a eight point list of factors that distinguish an addictive drug from non-addictive drug or addictive behavior from a non-addictive addictive behavior. Is that correct?
A. Yes.
Q. Do you wish to change any of that?
A. I don't think so.
Q. Doctor, the last time we got together, I had asked you a number of questions about your clinical impressions of Mrs. Boerner based upon your interview of her, your clinical impressions of Mrs. Boerner based upon your interview of her husband, and your clinical

impressions of Mrs. Boerner based upon the testimony that you have read that was taken of her, her husband and her son. Do you recall that?

A. Do I recall your question?

Q. Do you recall that we talked about those things?

A. Yes.

Q. Do you recall your testimony in general about those matters?

Basically what I am going to ask you is this. You wrote a report that reflected those clinical impressions, correct?

A. Yes.

Q. And you told me at the time of the deposition that the information that you felt was important or factors that were significant with respect to your diagnosis was contained in your report. Do you recall that?

A. Yes.

Q. Has there been anything to your knowledge that you have learned from the time of the last deposition until today that would change in any way your conception or your clinical impression of Mrs. Boerner?

A. I found the two depositions quite revealing. The Scoggins and I guess this was Mr. Boerner's second deposition.

Q. In what way did they change your clinical impression of Mrs. Boerner?

By the way do you have any notes of those depositions, Doctor?

A. Yes.

Q. Could I see them?

A. Sure. They are all my chicken scratches on the front page and I probably dog eared a few pages.

I will be right back.

Q. Doctor, with your permission, at the end of this deposition, I would like to mark the pages of the Scoggins and Henry Boerner deposition with your notes as Exhibit number 14 which 13 think is the next in order.

(Whereupon, Defendant's Exhibit 13A was marked.)

(Whereupon, Defendant's Exhibit 13B was marked.)

MR. SHEFFLER: Q. Is that all right?

A. Yes.

Q. Again, Doctor, I have read those notes and basically what I am looking for is how your clinical impression of Mrs. Boerner did change, if at all, based upon what you have learned since the last time we were together.

A. No, I don't think my impression has changed.

Clarified and sharpened a little bit how I conceptualized it. I think you heard this morning those differences or additions. That's the lot.

Q. I have a few issues that I would like to go over with you with the deposition from the last time if you have it available there.

First of all, at page 110, I asked you if you had a list of the workshops and you said that you would try to get it together and give it to counsel to send off to me. Have you done that?

A. No.

Q. Can you do that or is that --

A. I can't do that.

Q. Page 198, Doctor, the question was asked about -- this is talking about the compensation, Federal Trade Commission measurements and measuring techniques, et cetera. And I asked you the following question at line 18 on page 198.

"Question: So you really -- if I asked you questions about compensatory smoking techniques or measures, I mean it wouldn't be something that you are an expert on."

"Answer: "Not this afternoon.

"Question: Well, maybe the next time we get together.

"Answer: Uh-huh."

Are you an expert any further on compensatory smoking techniques or measures than you were back in August?

A. No, I am no smarter today than back in August.

Q. The question is --

A. No.

Q. Or do you intend to become one before the trial?

A. No.

Q. I can't point to you a specific page but I believe that in our discussions last time we talked about the state of the art evidence on smoking and we talked about when a consensus would have been reached. You gave me your views as to when you believe there was evidence, et cetera. But you told me at that time that really to reach an opinion about consensus you would want to look at such things as what the history of the DSM is in terms of smoking, major review articles, textbooks and a bunch of other things.

My question is this, Doctor. Have you done anything in terms of trying to ascertain the evidence about the state of the art with respect to addiction and how tobacco or nicotine fit within that historically?

A. No.

Q. Do you intend to do so?

A. No. My opinions as expressed in August are the same opinions that I hold now and will hold in April.

Q. You are not -- I don't want to be surprised that you are expanding into a scope that you told me in August you didn't feel you were prepared to address.

A. I am taking really great pains today to make sure you are not surprised. Even though you resist what I have to say, I am going to make sure that you hear it so there are no surprises.

Now I did expand a little bit today I think on the concept of addiction in my opening remarks. But I think you have now plumbed the heights or the depths of my knowledge in that area.

Q. I haven't begun. Let me just tell you, Doctor, I do appreciate it. When I say I don't want to hear what you say, I do not want to hear that which I do not believe you are entitled to talk about at trial or deposition, for that matter is scandalous attack such as calling an industry of people sociopathic or of me as agent for a sociopathic industry. I think that is improper and I will move to strike that. It is certainly not any direct commentary upon you or your expertise or any other. It is just not proper in my view which is why I move to strike it.

If you want to, I can't stop you from talking

about it. You can call tobacco companies and its personnel anything you want. But I will move to strike. And I don't want to you be offended by that. It is simply what I believe is necessary to preserve the record.

A. Yes.

Q. Doctor, last time we got together we talked about a word call tachyphylaxis. Do you recall that?

A. Yes.

Q. And I referred you to the second chapter of the Surgeon General's report for a description of acute tolerance or tachyphylaxis?

A. You did.

Q. And that was in conjunction with this testimony that Mrs. Boerner and her husband had given about how she would increase her smoking twice what she had previously done after a day of abstinence. Do you recall that?

A. Yes.

Q. Did you look at the Surgeon General's report on that?

A. I didn't. I get a demerit.

Q. That's fine. Does it matter to you whatsoever whether what Mr. Boerner said about how his wife would smoke twice as many cigarettes a day after abstinence when she was smoking regularly, does it matter to you at all whether that would be under the rubric of the Surgeon

General's report, whether that would be something that would create a condition of nausea and nicotine toxicity in Mrs. Boerner?

A. Yes, it is of interest. And I wasn't being cavalier about my not looking at that reference. In truth, I forgot all about our discussion. We discussed a lot of things. It wasn't until I got my copy of my deposition yesterday that I read that. In fact, I read it -- I finally got to it about 2:00 in the morning and I just haven't really had a chance to do that. So that is one area where I think it would be prudent for me to check that reference. It does seem to be an area that falls within our purview and I will but I haven't done it yet.

Q. Doctor, how many millions of smokers are there today?

A. I don't know.

Q. Give me an estimate.

A. I couldn't. I don't know how many millions of people there are in the United States.

Q. 200 million people in the United States.

A. 25 to 32 percent are still smoking I understand. So you say how many, 200 million Americans?

Q. Roughly.

A. Then it would have to be about 60 million smokers.

Q. What percent of smokers typically smoke a pack or more a day?
A. A majority of those. I don't know if it is a big majority or small majority but I would say a majority of those.
Q. I am asking you these questions because you did tell me you are relying on generic smokers for Mrs. Boerner.
You would be surprised to know -- strike that.
What is a chipper in smoking terminology?
A. A discretionary smoker. Someone who might spoke three or four cigarettes New Year's eve and maybe not pick up a cigarette for another month or might smoke one or two cigarettes a week.
Q. If I understand, Doctor, a non-discretionary smoker is a smoker who smokes everyday?
A. Yes.
And they usually find their optimum level. Whether it is a pack or pack and a half, they tend to stay at that for long periods of time.
Q. Do you have any idea of what percentage of smokers are discretionary smokers?
A. I have seen different figures. I don't know who to believe. So I would say it is less than 10 percent.
Q. There are figures that say less than 5 percent

of people who smoke less than five cigarettes a day?
A. I have seen those. Less than 20 percent. It may be less than five.
Q. Do you believe --
A. I think at my first deposition I said 5 percent but I have read things which say it may be more than that.
Q. I don't think I asked you in the deposition. Maybe it was a different case.
A. No. I read it last night.
Q. One of the things you said -- by the way, have you read trial testimony other than the Carter case?
A. I have read excerpts of trial testimony, yes.
Q. Do you recall which trials?
A. No.
Q. Where did you get them?
A. The American Psychiatric Association has had a discussion of this and they had excerpts hither and yon.
Q. Who led the discussion?
A. I don't remember.
Q. You don't recall anybody who was talking at that discussion?
A. It was a article of a transcript of a discussion probably from one of the conferences.
Q. Getting back to the percentage of discretionary smokers, has it changed significantly in the past ten

years?
A. I don't know.
Q. 20 years?
A. I don't know.
Q. 30 years?
A. Don't know.
Q. Do you know whether the percentage of smokers has changed significantly in the last 30 years?
A. Yes.
Q. But you don't know whether the percentage who smoke a pack or more a day has changed at all in the last 30 years?
A. That's correct.
Q. Is everyone who is a non-discretionary smoker an addicted smoker?
A. Yes. But addiction like other disorders can be mild, moderate and severe. So that I could see where somebody's addiction comes from because they are blessed with a certain kind of genetic constitution, is so modest as to almost be indistinguishable from a discretionary smoker. In other words, discretionary smokers may be on a continuum with addicted smokers but that the person who, if you put a gun to their head and you say if you light up another cigarette, after an hour or two they are going to say 'fire away but I am going to light up a cigarette.'

So there is a continuum. And that is why I believe some people quit with relative ease and some people can't at all. They are both addicted. Some people are lucky and some people are not.

Q. Some people quit with relative ease and they are addicted?

A. My dad smoked two packs of cigarettes a day for 30 years. He had his first coronary. He quit. Apparently it was not a difficult thing for him to do. My mom who smoked half a pack a cigarettes was never able to quit, though she tried. Women for some reason have more difficulty quitting than men.

Q. Do you have any empirical evidence to support that statement?

A. It is anecdotal.

Q. Do you have any evidence, Doctor, in a published peer review journal, Surgeon General's report, in anything that you are aware of to substantiate that attitude?

A. No.

Q. Are you aware of peer review journals, Surgeon General's reports and other materials, that say that that impression is incorrect?

A. No.

Q. You are not. If I were to show you such, would you agree that maybe your impression is incorrect?

A. Maybe.
Q. We will get to that.
Let me ask you this. Doctor, is it your view that people who are non-discretionary smokers will exhibit withdrawal upon cessation?
A. People who are not non-discretionary?
Q. People who are non-discretionary smokers, i.e. addicted smokers, will exhibit withdrawal upon cessation?
A. It depends on how you define withdrawal. If you define it as having heart beat and inability to sleep and great difficulty concentrating, things that can be objectively measured with reasonable ease, I would say sometimes. That is, some individuals will exhibit that and some won't. But they will all exhibit to greater or lesser extent the sense of somehow not being themselves, of being abnormal, a dysphoric state that persists until they light up again. I think they will all, if they are addicted then, by my definition, they will all have that symptom.
Q. What you are saying, if you are addicted, you will have this dysphoria and you have this dysphoria because you are addicted?
A. That's what a sine qua non is.
Q. Let me ask you a different question. Do you have any evidence to substantiate the fact that everybody

who smokes a pack or day or more and quits smoking will suffer withdrawal? In other words, Doctor --

A. I heard your question.

No. I think that the literature would suggest that not everybody does have classical physiological withdrawal symptoms.

Q. The literature also suggests as does the Surgeon General's report that psychological withdrawal is not universal, either, is it?

A. I would have to see the citation before I would agree to something.

Q. Do you have your Surgeon General's report handy?

A. Why don't you show me.

Q. Surgeon General's report 1988, page 200, which states collectively and is reviewing just to put it in context retrospectively survey data, and it says, "Collectively, the results of many such studies suggests that most nicotine-deprived cigarette smokers experience at least one symptom of the tobacco withdrawal syndrome; that between one-fourth and one-half show significant withdrawal and that about one-fourth report no withdrawal at all." Do you see that?

A. Yes.

Q. And then there is a list of citations.

Do you agree with that?

A. Yes.
Q. Doctor, if I may, what they are talking about is craving for nicotine, irritability, frustration, anger, anxiety, difficulty concentrating, restlessness, et cetera --
A. That's classical withdrawal.
Q. So you don't have any problem with the statement that at least one-fourth report no withdrawal at all?
A. Correct.
Q. How then can you say that one-fourth of the persons who smoke a pack or more a day are necessarily not addicted, that they can show no withdrawal?
A. Could I have that read back?
Q. Let rephrase it. It is a poor question.
According to the Surgeons General's report, at least one-fourth of smokers who quit report no withdrawal at all.
A. Yes.
Q. Would you agree that those smokers were not addicted based on your sine qua non that addiction shows when you quit you feel abnormal?
A. No, I can't agree. They may not be addicted, however. As I say, there is probably a continuum between people who are moderately addicted and what we agree to call discretionary smokers. So that when in these studies

25 percent report no withdrawal, it may be that their symptoms of withdrawal do not reach the threshold test for that particular protocol.

Q. I can show you the studies. John Hughes wrote a study, you might want to look it up and read it, called Signs and Symptoms of Tobacco Withdrawals published in 1986, in which he basically looked at people. Zero, no change upon cessation; one, mild change; two moderate, change; three, severe change. In all of the features at that time that were under examination for withdrawal, what he found was that most of the people reported a mild change. What he also found was that it wasn't universal, as did the Surgeon General.

Given that, Doctor, would you agree that people who smoke cigarettes and are non-discretionary smokers under your definition may not be addicted?

A. No.

Q. Let me put the question more bluntly.

To be addicted according to Dr. Blinder, must you have withdrawal when you quit smoking?

A. Yes. But the withdrawal symptoms are larger or more subtle than that list. Those are objectively measurable, I think fairly objectively measurable symptoms. What I am suggesting to you is that there is another feature of withdrawal that is not on that list

which to the best of my knowledge was not part of the protocols of which that list is a summation and that is the sense of being normal. Now perhaps that is -- maybe that list subsumes some of the characteristics of being normal versus abnormal. I would need to know -- I would ask this 25 percent, okay, you don't feel anxious. Are you still able to go to work and concentrate as well as you ever did. You don't have a craving for cigarette. Let me ask you, do you feel any different now three or four hours later. I would also ask them that question in 24 hours and in 48 hours and 76 hours.

I don't know what the time frame of these various tests are because I think people probably experience their absence from tobacco different depending on when you ask them the question.

Q. The signs and symptoms that I referred to was at only 30 days but there have been subsequent studies taken out for six months. But let me ask you a follow up now, Doctor.

What is the test? Do you simply ask people do you feel different now that you have quit? Is that the question?

A. I think that's a good place to begin, sure.

Q. How do you distinguish, Doctor, that what people experience or what they testify to would tell you about is

not merely the emergence of psychological traits that were suppressed, controlled, or altered by the effects of nicotine or a behavioral reaction such as frustration to a loss of a reinforcer?

A. Counsel, I don't know what this is all about. At most all you do is identify that the category of discretionary smokers may be larger. That if we blur together people whose addiction is so mild they should be classified as discretionary smokers. It doesn't change the salient fact which is that smoking or tobacco is an addictive substance. Not everybody who chooses an addictive substance gets addicted. Whether it is heroine or cocaine. I don't know what the purpose of all these arcane questions are. It is not going to change my testimony.

Q. I have a right to plumb your testimony. You made a statement that I have no basis of seeing in anything that I have read. Certainly not the Surgeon General's, '88 report. Certainly not the studies or any of the journals that you reportedly read talks about a test of smoking withdrawal that you feel abnormal. I haven't seen that reported anywhere. I don't know what the basis for that statement is.

Obviously, when a person gives up a well-liked habit, they very well may feel frustration as a result of

the loss of a well liked reinforcer. It is not withdrawal and it is not nicotine induced. It is merely the fact that you have given up a well liked reinforcer which is what the DSM-III says.

My question to you is, if you claim that this abnormal feeling is a sine qua non of addiction and it is not withdrawal, it is something in addition to the withdrawal recognized by this '88 report and everybody else that says nicotine is addictive, what's the basis, where is your empirical evidence? Where is your proof?

A. Ask any smoker who has gone without tobacco for two hours and the movie has another hour to go and they walk out in the middle to light up what's going on there. Some of them will talk in terms of classic withdrawal symptoms but all of them will tell you I need this in order to feel okay.

Q. You have a study, Doctor?

A. No.

Q. Have you done this --

A. Counsel, I am here as an expert.

Q. You have to answer my question.

A. I am answering your question. I am here as an expert, as a work-a-day physician and psychiatrist. I have been in the field for 35 years. As a consequence, I am a vehicle for bringing in a medical consensus. You can

challenge that medical consensus, the prevailing Zeitgeist of what those of us who are reasonably conversant with these issues believe. It is based on 35 years in the field, practical experience and, God knows, I am not a research scientist. God knows I am not conversant about each of these studies, but if you talk to most physicians in the field, they will say more or less what I am saying to you today. I don't have to be able to back up everything that I think with a study and I will tell you that almost every basic principle in medicine and psychiatry there are studies that are in conflict with that. It doesn't change the fact that your product addicts most people albeit different people respond to that addiction in different ways.

Q. Doctor, you have to answer --

A. You need to further confuse and confound the jury and mislead them. It is a technique that your industry has been doing for 40 years.

Q. Doctor, I am going to move to strike that. If you want to take a break, take a break. Don't get upset and makes speeches.

My question was, do you have any empirical evidence and you told me you have no studies. You said it is based upon your practical experience.

My question was very simply, have you done a

study of your own, have you analyzed or have you collected data on the patients who you have treated? When you say asked smokers, have you asked smokers? How many smokers? What was the percentage of people feeling abnormal after quitting? What was the mechanism you used to test it? What was the control group that you used against it?

The question is one you would ask of any doctor or any scientist who was giving an opinion. You have given an opinion. I am just asking the bases.

A. Basis I have given you is 35 years in the field. No, I have not done a study, normal study. I have not established a formal protocol nor have I published such.

Q. Have you responded to the DSM-IV or the DSM-IIIR when they have put out their promulgations of tobacco or nicotine withdrawal? Did you respond to, did you write to the APA, did you write to the working group?

A. No, I did not.

Q. And said you have got it wrong guys.

A. No, I did not.

Q. Has anybody said that to them to your knowledge?

A. No, I don't know.

Q. Do you know whether there were field trials for the criteria of nicotine withdrawal?

A. No, I don't.

Q. You haven't looked at them if there have been,

have you?
A. No.
(Recess taken.)
MR. SHEFFLER: Q. Before the break we were talking a little bit about withdrawal and some empirical evidence of same. Let me ask you about cessation, cessation statistics.
At our last deposition you gave us some of your views about cessation. And I think you said that 50 percent of smokers have quit smoking but it takes them numerous tries to do so?
A. Yes.
Q. Do you have any empirical evidence, Doctor, for that statement?
A. I have read things if that's what you mean. I have read studies. People have actually tried to reduce a clinical impression to a statistical formula. I think the average, if you take the people who quit first time, average amount took seven or eight times, so it averages out three times.
Q. Let me ask you this, Doctor.
If a study of people who have quit for over a year and remained abstinent until the time in which they were interviewed demonstrated that the number of quit attempts for the majority of people who have successfully

quit was one or two, would that be surprising to you?
A. I thought it was two or three, but all right.
Q. Would it be surprising to you, Doctor, that the numbers of cigarettes smoked per day did not distinguish between a person who was successful and a person who was not successful?
A. No.
Q. Would it surprise you, Doctor, that the indication -- strike that.
Would it surprise you, Doctor, that advise from a physician was not a predictor in whether you were successful quitting or not successful quitting?
A. No.
Q. Would it surprise you that there was no significant difference between male and female in terms of succeeding in quitting?
A. Yes.
Q. That would surprise you?
A. Yes.
Q. Do you have data, Doctor, that would suggest that there is a difference between male and female?
A. It has been my impression over 35 years. I have no studies.
Q. How many people have you followed who have quit smoking? Have you followed for a year?

A. I couldn't tell you.
Q. Give me an estimate.
A. I couldn't estimate.
Q. Is it more than ten?
A. It isn't so much those people that I have personally followed, those people I see in my practice, those people I know as a result of six plus decades on this planet plus all the studies. It is a confluence of all sorts of information. That's why I can't identify a particular source.
Q. I want to do it systematically. First of all, you don't know a study that shows a difference between gender with cessation?
A. That's correct.
Q. And you don't know -- have you looked, Doctor, at the Surgeon General's report to see if they record a difference between cessation with gender?
A. I haven't specifically looked for that, no.
Q. You cannot tell me from your own practice the number of people that you base this impression upon?
A. No, I cannot.
Q. And, therefore, what we are left with is your 60 plus years on the planet where you have seen people who have quit smoking?
A. Yes.

Q. But you have not followed any of these people for a year to determine whether or not they quit smoking and remained abstinent?
A. I have done no systematic study. I have no systematic formal scientific data to back up my impression. I could not seriously expect to publish my impression in a peer review article. I am aware of the relatively lower level, if you will, of having this kind of anecdotal impression but that's what I have got.
Q. Is it important in your opinions that there is a gender difference or not a gender difference in cessation?
A. I don't see where it would be applicable to this case.
Q. The 50 percent of smokers who quit smoking in the past 30 years, let's say, you would agree that the majority of those, the vast majority of them smoked a pack or more of cigarettes a day, would you not?
A. That's my understanding.
Q. The vast majority of those would be discretionary smokers according to your view?
A. Yes.
Q. And you would agree the vast majority of those were addicted, right?
A. Yes.
Q. And yet the vast majority of those, all of those

quit smoking and the vast majority of them did so without any medical intercession whatsoever?

A. Yes.

Q. On their own?

A. Yes.

Q. 90 percent?

A. Yes.

Q. And you would agree with that?

A. Yes.

Q. You told me at one point that the strength of addiction as well as addiction was correlated with successful cessation. Do you still hold that view?

A. When did I say that?

Q. You said that in the last deposition.

Do you want me to get it for you?

A. Please.

Q. "Do you believe that a diagnosis of addiction should equate with a difficulty in quitting."

A. What page?

Q. Page 307, lines 24.

Starting actually I guess at lines 21.

"Question: Do you believe that people who are addicted have more difficulty in quitting?

"Answer: Yes.

"Question: Do you believe that a diagnosis of

addiction should equate with a difficulty of quitting? Should there be a correlation between the two?

"Answer: There is a correlation between the two.

Okay. Should it be a correlation such that, as your diagnosis of addition and the severity of addiction increases, the difficulty in quitting and the predictability, that a person will successfully abstain upon cessation increases?

"Answer: Can I hear that again?

"Question: Yes. Is the severity of addiction an accurate predictor of abstinence success?"

And you said yes.

Do you still hold those views?

A. Yes.

Q. 50 percent of the folks who have quit smoking, the vast majority of them do it on their own and also the vast majority smoking one pack or more a day. But those people did quit, correct?

A. Yes.

Q. And, therefore, if I understand what you are saying, those people were mildly addicted?

A. Because they quit?

Q. Yes.

A. No.

Q. Let me make sure I understand. Dr. Blinder believes that the severity of addiction correlates with the ability to quit successfully?
A. That's correct.
Q. Therefore, if people are able to quit successfully, does that mean they are heavily addicted or mildly addicted?
A. No. You can't -- you made an illogical leap. There is a correlation between the severity of addiction and your ability to quit. But this is not to say that people who are heavily addicted don't quit on the first go around versus somebody who is at the milder end of the continuum and seems to need five or six times before they finally quit for good. The fact that there is a correlation doesn't make it a perfect relationship.
Q. So if somebody is heavily addicted and they quit on the first time around, somebody who is mildly addicted takes four or five times to quit successfully, Doctor, in your opinion what is the difference between the two? Why is the heavily addicted person able to quit the first time around and the mildly addicted person four or five times to quit?
A. I don't know. I can give you an example that kind of answers your question but not to my satisfaction.
Let's say you are heavily addicted and the

doctor examines you one day and turns out you have lung cancer and your odds are not good but they are better if you quit smoking. Versus someone who has been smoking nine or ten cigarettes a day maybe not everyday and her husband has been after her for 20 years to quit and she tries and she doesn't. She has been able to go without cigarettes in relative comfort and she maybe gets by two or three days and the hell with it I am going to start smoking again. She goes back and she goes through five or six of these abortive efforts to quit at her husband's suggestion before she succeeds. She is mildly addicted and it takes her a long time.

The guy who has been smoking two packs a day who can't sit in church for an hour and he quits like that. The difference is that he has got a malignancy pointed at his head and she has a husband who is taunting her with his constant harping on her smoking. So there is an example of someone who is mildly addictive who has more difficulty if you simply measure success rate and cessation than the fellow who has been a chain smoker and he quits the very first time. There is I suppose a difference in motivation. That's one possibility.

Second possibility is that we are genetically different. And there may be a genetic difference in the degree to which we are wedded to our addictive substance.

That is not reflected simply in how many of that substance we use. So to use my two examples again, the woman -- forget her husband now, she is a light smoker. She goes sometimes without smoking. She has relatively few of the classical withdrawal symptoms but she may have a genetic weakness that the heavy smoker does not, a weakness which is not reflected simply in the traditional measures of addictiveness such as the amount of the addictive substance consumed. Now I give you these examples. I am bordering on speculative. I don't know to what extent these examples would account for all of these differences but there are some of the variables that we would have to take into account.

Q. The first explanation you gave, motivation, that's not speculation. There are empirical studies, there is data to show that the more highly motivated a person is to quit, the higher the success rate of successful abstinence?

A. Yes. There are such studies but it is speculative to say that because that applies to certain smokers, that accounts for all the discrepancy, that applies to all smokers. I gave you a second example that had nothing to do with motivation and that was genetic structure. And there may be three or four other explanations that don't come to mind.

Q. Let me give you another explanation. First of all, by the way in your review of the Surgeon General's General's report, did you see anything in there that suggested that a genetic differences was a predictor or was responsible for the difference in cessation rates amongst smokers?

Was there any discussion of genetics?

A. Only discussion of genetics was that there is a lot of lung cancer in your family, you are genetically predisposed to get lung cancer.

Q. In the '88 Surgeon General's report?

A. I thought so. It was a very mild correlation. That's the only thing that comes to mind.

Q. Doctor, let me ask you about the other explanation perhaps that has been expressed in the Surgeon General's record. That's the construct, if you would, of self efficacy. In other words, if a person believes that they can do a certain action, they are far more likely to accomplish it than if they don't believe they can do it.

A. Makes sense.

Q. You are familiar with that?

A. In truth, the word self efficacy did not ring the bell but the idea behind it seems reasonable to me.

Q. Are you familiar with the Bayean model, health belief model for explaining this?

A. I am not familiar with it under that name if I am familiar with it at all.
Q. You are familiar with health belief models, though?
A. I trust.
Q. Are you not familiar with the idea amongst persons examining human behavior that if one feels they are empowered with a lifestyle change, they are more likely to succeed?
A. Yes.
Q. So it could be that a person who believes that they are hopelessly addicted and cannot give up cigarettes will have more difficulty in giving up cigarettes than one who thinks they have the power to give them up?
A. Yes.
Q. All else being equal?
A. Yes.
There is a flip side to that, however, which I would be remiss if I let it go by which is that if the individual has been persuaded that they don't have a problem, they don't therefore require a solution, especially a solution that might cause some discomfort. And pain, as the tobacco industry has constantly told smokers until for most of them it was too late, they don't have a problem, they have a habit, they are not addicted.

If they don't have an addiction, they don't have a disorder; ergo, they don't have to put much energy and effort to solving a problem which in the tobacco industry's lexicon if it doesn't exist, it is of trivial consequence.

Q. Let me back up a second. I was talking about self efficacy. What you are talking about effects motivation to quit or not quit, correct?

A. I was talking about a substrate, a precursor to self efficacy. Before you can get to self efficacy, you have to identify that there is a problem about which you need some philosophical optimism that you can solve.

Q. So the first point is motivation. Once you have the motivation, it would be useful to have the self efficacy so that you can solve it?

A. Once --

Q. If you have the motivation --

A. You can't have motivation until you have a problem. You have to be motivated to solve a problem. The tobacco industry has made it seem as if you don't have a problem. You just have a habit. You have a pleasure. You don't have a disorder. You don't have an addiction. That's exactly what the industry has done for years and that's what happens at these trials. But not at this one.

Q. Let's break it down. The first thing a person

has to recognize is that they have a problem and that could be either, one, they are hooked on cigarettes or addicted to cigarettes. And if they use the term hooked instead of addicted, do you have a problem?

A. It is certainly better than saying they have a habit. But it is ambiguous. It is again the tobacco industry's preference to keep those concepts fuzzy and ambiguous.

Q. If people understood -- if a person understood that she has a significant difficulty in giving a substance up, that she needs it, her body needs it, she craves it, she can't live without it, is that the equivalent of knowing she is addicted?

A. Yes. But --

Q. It is better than telling her she is addicted because she knows what the consequences are, doesn't she?

A. There is certainly great virtue in characterizing this phenomenon in terms of the consequences, the adverse consequences. But by avoiding the word addiction, you are giving the addict an out. They think, well, if you say I am an addict, they think of those people on the street, the junkies in the street and they don't want to think of themselves because those people really have a problem. Well, guess what, they are like the junkies in the street and the sooner they

recognize that, the more rigorous their efforts to cure the problem. Whereas, if they are hooked, again it is sufficiently wheezly a word, it is not that bad. It is not a disease. It is not a disorder. It is just a weakness.

Q. Let's say they recognize this is terrible, they can't live without it. They need it. All those things.

A. I will accept that.

Q. And they have a problem. Now the second step is they have the problem. Now the next step is they are motivated to quit. Now we go to the self efficacy point. If they truly believe they are a helpless addict and there is nothing they can do to get rid of this terrible problem, are they more likely or less likely to succeed than if they think they can deal with the problem?

A. Less likely.

Q. So in other words, self efficacy is important?

A. Yes.

Q. Are you familiar with the discussion of whether a craving should be a part of tobacco withdrawal syndrome?

A. Yes.

Q. Why do people believe it should not be a part of the tobacco withdrawal syndrome?

A. It is subjective. It is difficult to measure objectively. It is not necessarily associated with change

in heart beat, respiration.

Q. Isn't it true, Doctor, that one of the reasons why craving is not regarded as a function of withdrawal is because there is no change in the level of craving pre or post abstinence; in other words, people have significant craving while they are smoking, isn't that true?

A. That's news to me.

Q. If it were news to you, Doctor -- strike that.

I am reading at page 210 of the surgeons General's report. Tobacco Craving.

"The measurement of self-reported craving for tobacco and interpretation of resulting data are among the more complicated issues of tobacco research. Findings discussed in this chapter of nicotine procrilex gum administration can suppress cigarette smoking and alleviate withdrawal while having little effect on the urge to smoke indicate that such urges are not solely determined by nicotine deprivation." And furthermore, talks about craving can be replaced by urge or desire. Urges can also be elicited by a variety of other stimuli including cigarette smoking itself. So in other words, one of the things that people have suggested is that smoking itself will result in craving. People crave cigarettes as they smoke them.

A. You made another leap.

Q. Let me strike that then. I don't want to make a leap.

Isn't it true, Doctor, that people do report craving for cigarettes even though they haven't quit smoking?

A. First, this is another example of your using some arcane sentence -- some arcane wording to confuse the trier of fact.

Yes, it is true that if someone who is in the act of smoking; that is, they have not made a decision to quit, has run out of cigarettes, until they can get down to the 7/11 to pick up their cigarettes, they are going to have a craving for it. They are not going to have a particular craving for a cigarette while they are smoking but they certainly are going to have a reaction to the fact that they are smoking it. And that reaction is subsumed under my rubric of feeling normal, that the smoker likes to feel normal. I suspected that what they crave is normality.

Q. Let me state it this way. In studies, not in just general impressions but in studies that have been peer reviewed and submitted to the American Psychological Consulting and Clinical Psychology which I purport you read --

A. I am familiar with it.

Q. In such peer review journals, there have been statements made such as "Craving did not increase after abstinence." In a study of tobacco withdrawals in self-quitters. "As in prior studies, craving ratings were high precessation;" i.e., before quitting.

"However, the present results do not appear to be due to ceiling effects as the mean precessation score was 62 on a 0- to 100- point visual analog scale."

A. So what?

Q. These negative results could be due to the use of the phrase "craving for cigarettes" rather than "desire for cigarettes" or because the term craving has a different meaning to smokers during smoking than during abstinence. Whatever the reason, the study craving failed to show a time limited increase characteristic of withdrawal.

A. So what?

Q. So in other words, craving is not a sign of withdrawal. Correct?

A. I don't get that at all.

Q. Is craving a symptom or sign of withdrawal as it is expressed in the DSM-IV.

A. I don't know.

Q. It wasn't in DSM-IIIR and I submit it is not one of the criteria listed on DSM-IV?

A. So what do we do with all those smokers who are trying to quit and now live in the age of DSM-IV? What are we going to do about their intensive craving? They were allowed to have it back in 1983 when we had DSM-III but now that it is 1999, they can't have it anymore. The fact that people take words in and out of these studies, what does that do to the person with the problem?

Q. Let me just back up a second. First of all, DSM-IIIR which was in '87. There was nothing in '83 DSM-IIIR in 1987 had the word craving as one of the criteria for nicotine withdrawal. It was eliminated by the American Psychiatric Association after clinical field trial studies because it did not reliably show a difference in severity pre quitting and post quitting.

A. So what?

Q. If people were asked to on a piece of paper check off how much they craved the cigarette pre quitting and how much they craved the cigarette post quitting, there was no change.

Okay.

You understand?

A. Yes. I hear what you are saying.

Q. Now, isn't that a reason for not including craving as a withdrawal symptom?

A. No, it is nonsense. How can you say -- I don't

care how many studies you design.

Q. This is your American Psychiatric Association which you belong to.

A. 20 years ago DSM eliminated the category of neurosis. That mainly eliminated 40 percent of my practice. 40 percent of my patients were neurotic. They may have eliminated the word. I still had to treat these patients. Sorry, Mr. Smith, I can't see you any more. According to the APA you don't have a psychiatric disorder.

I don't care about these studies and I am take umbrage at your using them to confuse the jury about craving.

People who quit smoking crave tobacco and I don't care what study you can show me, a study that says that the world is flat. It is not going to change the reality that the world is round. All these arcane studies don't change the fact that your product is addictive and when people can't get their hands on it, they have a craving for it.

Q. Can you point to me a single study, a single piece of empirical evidence to call into question the APA's decision to eliminate craving as one of the criteria for nicotine withdrawal?

A. I am not going to get into that. That's a trap.

It is a question that is certainly legally permissible but designed to confuse the jury and you are going to have to use somebody else to do that.

Q. I am not going to confuse the jury. It will be in the context of trying to establish the basis for your expert opinion. And just so you understand where my questions are coming from, you have a lot of impressions, you have a lot ideas. And you have a lot of biases and feelings. Biases, feelings, ideas, impressions may or may not be admissible at trial. They are, if they are expert opinion, based upon a certain degree of medical science or scientific research. To the extent that you have bases for them, that's fine. I am entitled to plumb them. That's what I am doing. I haven't found them yet. Maybe they are there. But until you can articulate them, I am going to continue to plumb.

The mere fact that you believe something very strongly or you are extremely biassed in terms of your feelings doesn't make it any more valid or admissible as evidence. It has to have scientific basis and validity. You may think that simply because you believe it real strongly it should be admissible. Dr. Blinder, that's not the rules that I am operating under or the rules the court will reply.

Sorry to take so much time but it seems that we

are getting a little confused as to what is going on. I am not trying to obfuscate. I am trying to find out if you have any scientific basis for some of these somewhat contradictory opinions at least in the view of what the surgeons General's report is.

A. Your use of these studies ostensibly to plumb the depths of my knowledge is in fact a device to distract the jury.

MR. SHEFFLER: Why don't we take a lunch break at some point.

(Discussion off the record.)

(Whereupon, Defendant's Exhibit 14 was marked.)

MR. SHEFFLER: Q. During the course of the last break, Doctor, we marked Defendants' Exhibit 14 for your deposition.

I want to show you that is a letter to Judge James Moody from Mr. Schulze with attachments. The first attachment which I really want to ask you about begins on the third page which is a letter dated September 24, page three and four, which is a letter that you authored on September 24, 1999. Is that correct?

A. Yes.

Q. Have you seen the attachment, the final attachment which is an affidavit by Mr. Schulze?

A. No.
Q. You haven't seen that before?
A. No.
Q. Nobody reviewed the contents of that to your knowledge with you?
A. I don't think so.
Q. Turning to your letter again, it states about the tobacco industry and what it could do or not do in the 1960's and '70's and it states basically on page two in short reading from the first full paragraph, "In short, though, no warning, however dire, comes with a warranty of success, there is much the industry might have done that would have increased Mrs. Boerner's will to quit, raised her consciousness as to the necessity, and denied her some of the reinforcements of her addiction." Do you see that?
A. Yes.
Q. First of all, I want to focus just on the very first part of this. I want to know focus on the first part alone which says, "In short, though no warning, however dire, comes with a warranty of success." Doctor, you are not, as I understand it, here in this letter retracting your testimony that you said on August. For the sake of completeness, let me get it out here.
"Question: But with a reasonable degree of medical certainty, can you state that if Mrs. Boerner was

told in an accurate and forthright manner by the American Tobacco Company in 1970 that smoking had all the adverse consequences that medical science knew at that time, can you state that she would have quit."

And your answer is, "No." This is page 236, lines 14 through 21.

And likewise you go on to state that with a reasonable degree of medical certainty you could not say that she would have continued in the face of such warnings. Correct?

A. Yes.

Q. You are not withdrawing that testimony. Is that right?

A. No.

Q. That is still your opinion as you state in this letter?

A. Yes.

Q. Again, I may ask you to refer to the Exhibit 14, look if you would at the affidavit, paragraph six. In this paragraph, the second sentence on paragraph six, "Dr. Blinder did not believe that any particular warning would have guaranteed that Mrs. Boerner would have discontinued smoking."

And that's correct, isn't it?

A. Yes.

Q. And it doesn't matter what that warning said or when it was said. That's your opinion?
A. Yes.
Q. If I substituted the words "instead of would have guaranteed" substituted the words "with a reasonable degree of probability would have resulted in," your answer would be the same. In other words, it would read, "Dr. Blinder did not believe that any particular warning would have resulted in Mrs. Boerner's discontinuing of smoking."
A. That's a little different. Little different.
Q. "Dr. Blinder does not believe that any particular warning would have resulted in Mrs. Boerner's quitting smoking."
A. That's different than what I said. I said there are no guarantees --
Q. What you testified to, Doctor --
A. Let's go back to the testimony.
Q. That was really Mr. Schulze's spin. What you testified to was, you could not state with a reasonable degree of medical probability that she would have quit.
A. I agree with that.
Q. Reasonably degree of medical certainty?
MR. SCHULZE: I would ask you to look at page 232, line 10.
MR. SHEFFLER: Gerry, is that an objection?

MR. SCHULZE: Yes, it is, because it misstates who used the word guarantee first. You told Dr. Blinder guarantee was not his word.

MR. SHEFFLER: I said it was not his word in paragraph six.

MR. SCHULZE: I thought you told Dr. Blinder just now that guarantee was my spin. That was not his terminology when in fact Dr. Blinder used the term guarantee in his answer on what appears to be page 232, line 10.

MR. SHEFFLER: Just for the record, since you raised it, let me say that the answer you are referring to responded to a question, "What could have been done to allow Mrs. Boerner to overcome her selective inattention."

"Answer: There is no guarantee. It wasn't with respect to warnings. It was what could have been done in general. But, nevertheless, since you made your objection, it is noted for the record for whatever purpose you thought it was important to do so."

Q. So you are not changing your testimony?

A. Now I am not sure what testimony we are talking about.

Q. The testimony that says with a reasonably degree of medical certainty you cannot state that a warning would have caused Mrs. Boerner to quit.

A. That's correct. That's a little different than what you asked me before.
Q. I don't know what I asked you before. Let me say Dr. Blinder does not believe that any particular warning would have caused Mrs. Boerner to discontinue smoking.
A. Yes, that's true.
Q. With a reasonably degree of medical certainty, Dr. Blinder is not able to stay bla, bla, bla.
A. Give me the bla, bla, bla.
Q. Is not able to state that any particular warning would have caused Mrs. Boerner to have quit smoking?
A. That's true.
Q. Doctor, let me go on to the letter because you state that there are many things that have helped many other Mary Jane Boerners and to a reasonable degree of medical probability could well have helped her either quit or to quit a lot sooner than she did. That's page 1 of your letter to Mr. Schulze which is Exhibit 14.
My first question is, what does that mean? Can you state -- when you say there are many things with a reasonable medical degree of probability could result in something, I don't know what that means. Does it mean that you are able to state that for this individual it would have?

A. No.
Q. So it means that there is a possibility that it would have, these other things?
A. Yes. I cannot indicate what warnings, if any, would have stopped her cold from continuing to smoke. Some warnings are more likely than others to have achieved that purpose. None of them can I assure you would have done the trick. But at risk of being a bit facetious, if we put a skull and crossbones on the cigarette packs, it certainly has worked for rat poison. It might work for cigarettes, too, although with an addict, not necessarily.
More to the point, there were things that the tobacco companies do concurrent with the issuance of warnings that serve to endow them or vitiate them. That's what I am talking about when I say there is more that the tobacco companies could have done and that I believe to a reasonable degree of medical certainty can shorten the addiction time.
If we gave this woman another ten years, she might have not gotten lung cancer.
Q. That's one of the things I want to explore, these other things that could have been done to vitiate the information she was being given.
First of all, do you know how big American Tobacco Company was in the 1960's?

A. I do not.
Q. Do you know what the major tobacco companies were in the 1960s?
A. What they were?
Q. Do you know which ones were the major ones, the biggest?
A. I have known that in the past. Let me see if I can roll it up here.
RJ Reynolds was a big one. Phillip Morris. There have been a couple of merges. Wasn't the American Tobacco Company a separate entity of Myers? Liggett & and Meyers is another one.
Q. I want to focus just on American. American Tobacco was a company at that time that manufactured cigarettes?
A. Right.
Q. It is the company that manufactured the cigarettes she bought, right?
A. All right.
Q. If American alone had not been involved in the or stopped being involved in the campaigns of disinformation or however you want to phrase what you think were vitiated warnings but all the rest of the tobacco companies continued to do the same, what difference would it have had for Mrs. Boerner, or can you

say?
A. We have no way of knowing. Again, if you are asking what a reasonable assumption from someone with my experience and background would be, I would conclude not much.
Q. One of the things that you have said in your report and testified in the past is that Mrs. Boerner testified, and you confirmed in your interview of her, that she did not quit because of health concerns?
A. That's correct.
Q. Health concerns were not high on her list of reasons for quitting?
A. That's correct.
Q. But she was not ignorant of the health association between cigarettes and her own health. That's a clumsy question. She was not ignorant of the fact that cigarettes could cause her health problems and death, was she?
A. I am sounding like Bill Clinton but can you define what you mean by ignorant.
Q. First of all, she was aware that cigarettes could cause her health problems and death?
A. And I know you are taking the deposition, but can I ask you what reference you have in mind when you say that she was aware. Is it something I said or something

in the reports? Where did you get this?
Q. Her husband told her that smoking could kill her. Correct?
A. I have just read his deposition and I don't remember him saying that.
Q. Or her son told her that smoking could kill her, correct?
A. Did he say that? I know the son came back from school -- I think the son did have some health warnings that the husband and wife both deny. I think the son --
Q. The husband and wife both deny.
Do you have the wife's deposition there?
A. No. I haven't read it in three, four months so if you have a quotation, I am merely asking for it. That's all.
Q. I am getting it out. I don't expect you to have total recall. But this is at page 52. I will read it. This is deposition of Mary Jane Boerner, page 52.
"You recall your husband urging you to quit smoking.
"Answer: Correct.
"Question: Did he ever say anything to you back in the '50s like, that's killing you?
"Answer: That's not in the '50's. No, sir. He did later on.

"Question: When did he first start saying that?
"Answer: I would say around '75, '78, something like that."
A. Okay. We have got it.
Q. "When did your son first start urging you to quit smoking"?
"I would judge when he was about ten years old. Now, they had lessons in school and instructors about what harm cigarettes could do to you. I don't recall the year that started.
"Did your son tell you, "and again page 53 -- "was he more specific? Did he ever say anything like smoking causes lung cancer."
"Answer: He said, 'Mom, it can kill you.'"
Now you also know from Mr. Boerner's deposition that he was an avid reader of the newspapers. And he testified that he read them all the time because that was his job.
And you are aware I presume that the number one news story or one of the leading news stories in the 1964 period was the Surgeon General's report?
A. Yes.
Q. In fact, it said -- I got this from a CDC history. Goes through this business about how they kept the reporters in a room, had it over the weekend because

it was such oppressive news coverage, that they were afraid it would have a tremendous affect on the stock market. Finally the doors were open. The news was spread. For several days the report furnished newspaper headlines across the country and lead stories on television news casts. Later it was ranked among the stop news stories of 1964.

MR. SCHULZE: What's the source for that?

MR. SHEFFLER: CDC Tips on Surgeon General's report 1964. We will make it number 15.

(Whereupon, Defendant's Exhibit 15 was marked.)

MR. SHEFFLER: Q. On the next page of 15, it talks about the fact that the Public Health Service last supported highly successful school and community programs in smoking and health.

I read that to you, Doctor basically to set up the following questions.

With respect to Exhibit 14, if you would turn with me to Exhibit 14, paragraph -- I'm sorry, do you need to take some time?

A. Okay.

Q. Mr. Boerner's deposition which you recently read was referred to in the affidavit. What was referred to was not the most recent deposition. It was from the first

deposition.

Paragraph 8 of the affidavit of Mr. Schulze. He quoted the following.

MR. SCHULZE: Is this an affidavit or brief I filed?

MR. SHEFFLER: I thought it was an affidavit. Is it a brief? I guess it is a brief, sorry. I stand corrected. Thank you.

In the brief Mr. Schulze filed, he quoted the following. He said, "There is other evidence that an adequate warning would have made Mrs. Boerner quit." I am not asking about that.

Henry Boerner testified that it may be harmful to your health did not tell the Boerners much. He then testified, "Do you believe if the 1984 warnings, like, for example, it said cigarette smoking may cause lung cancer, do you believe if there were such warnings in the '60s that your wife would quit smoking?"

"Okay. The warning was cigarette smoking may cause lung cancer."

He said, "I think she would have tried harder, yes, and I would have pushed her to try a lot harder if we had a decent warning."

Do you see that?

A. Yes.

Q. Do you believe him? Not about her but about him.

A. Seems reasonable. Sure.

Q. In 1964 he would have read in the Little Rock paper about the Surgeon General's report. There were a series of days where they reported findings of this report which, among other things, said it was the major cause of lung cancer and other death dealing disease especially in men, a blue ribbon federal panel reported today.

Then it went through the points of this blue ribbon panel. Said cigarette smoking far outweighs all other causes of lung cancer in men and the data for women point in the same direction, even though it didn't reach a causal connection for women at that time.

Now, would he have seen that and if so, assuming that he did, assuming that it is probable that he did or saw other headline reports following, would he have urged his wife to quit as he said he did?

A. Of course there is nothing about my expertise as a psychiatrist that enables me to say better than anybody else what newspapers he read, what he saw, what he didn't see. Obviously, if he swore under oath he read the papers everyday, we have to assume that he would have read that as well. But I have no special expertise to allow me to assert that.

Q. But as someone who has interviewed him and read his depositions, you didn't think he was lying about that?
A. No, he read the paper. And if he read the paper, he would have read that and it would seem reasonable to me as just an ordinary reasonable human being that he would have taken the issue of this up with his smoking wife.
Q. And he would have told her smoking causes lung cancer?
A. Yes.
Q. So he would have done what he said he did, he would have done according to Mr. Schulze's brief?
A. You would think so.
Q. So it isn't that she didn't get this information about smoking and lung cancer from a source that she credited. Correct?
A. Correct.
Q. Also the son, she said that the son told her that smoking could kill her. She it said was when he was in school.
But last year -- and I want to -- we are going to mark this. Marked 16.
(Whereupon, Defendant's Exhibit 16 was marked.)
MR. SHEFFLER: Q. Doctor, direct your

attention to the second page. We talked about Panel Warnings of Danger of Smoking, January 12, 1964. Young People Told of Smoking Dangers.

If I direct your attention to the second paragraph, "Last year, 75 percent of Arkansas high school students were shown films and given literature in an attempt to prevent them from smoking or persuaded them to stop.

"The program was recognized by the American Cancer Society as one of the nation's best, said Tom Snodgrass, director of the Arkansas division.

"Cancer society hopes to reach every fourth, fifth and sixth grade pupil in Arkansas this coming year."

So if Gary Boerner would have been -- he graduated high school in '73. So in '64-'65, he would have -- in '65 he would have been -- seven years before -- wait. He would have been in fourth grade, would he not?

A. Something like that.

Q. So this is probably information that he was telling his mother about?

A. Probably.

Q. So not only did she remember that somebody told her this, although she remembered it perhaps later than maybe it really happened, but she did remember getting the information?

A. Right.
Q. That didn't figure in her quitting, though, did it?
A. No.
Q. She didn't quit because of the warnings?
A. No.
Q. And you have no information or evidence from her testimony or interview that she learned anything after the warnings she got from her husband or son in the mid '60's about smoking and lung cancer?
A. We have no information, no.
Q. To your knowledge, she never had another warning from that time until she quit in 1981 about the danger of cigarette smoking?
A. As far as we know, yes.
Q. And nevertheless she did quit?
A. Yes.
Q. I want to show you another poll that was conducted for the Tobacco Institute by Ropers. It was a series of questions that Ropers did and reported on. And I want to show it to you and ask you about it if I can find it here.

(Whereupon, Defendant's Exhibit 17 was marked.)

MR. SHEFFLER: Q. Doctor, take a look at the

second page of Exhibit 17. You see where it says there is a question and then there is a series of responses and there are some writings of people who responded.

Do you see that?

A. Yes.

Q. The question was, simply, "Here is a list of reasons people have given as to why they continue to smoke despite having seen warnings about smoking and health." Would you read over the reasons and then tell me those that come closest to explain why you still smoke despite the warnings asked of cigarette smokers."

Do you see that?

A. Yes.

Q. Of those explanations, which one do you think would most likely fit Mrs. Boerner? Which one would she have responded if she was answering this in 1972?

A. My answer is based in part on my examination of Mrs. Boerner and reading her and the family's deposition and in part on my genetic impressions of smokers' thinking and she is a member of that group.

She might well endorse several. And I would add one that I think in a manner of speaking she would endorse but which is not on the list which is that the smoking warnings did not register, they did not appear to be imperative. We know she would have had to have been

inundated by public health materials since 1964 and yet she testified she was not. Since she was not living on Neptune, we have to assume that she did have exposure to it. So though smokers don't use words like selective inattenion, I think that in some form should be on the list and the one which she would most appropriately endorse as well as several of the others.

Q. The one that has the most significant response among the people interviewed was "I enjoy smoking and don't want to give it up." Do you see that?

A. Yes.

Q. You have read Mr. Boerner's testimony where you said the reason why she didn't quit with urgings was because she really enjoyed smoking?

A. He would say (A) she enjoyed it and (B) she said she was hooked on it, and I discussed at excessive length what I think the word enjoy means when it comes from the mouth of a smoker.

Q. Whatever the reason, you saw Mrs. Boerner's testimony?

A. Yes.

Q. And she said, whatever she meant by enjoy, she said she really didn't want to quit until 1981. You saw that?

A. Yes.

Q. So the issue, whatever the rational reasoning behind it, Mrs. Boerner's first serious attempt to quit permanently was 1981?
A. What do you mean by serious?
Q. In the other attempts she said as did Mr. Boerner, -- strike that.
Let's take them one at a time. They both said different things.
Mrs. Boerner said that she didn't want to quit for herself until 1981. Her other attempts were for others. Much like the example you gave of the person who was a non-discretionary smoker and yet was quitting because of being constantly nagged versus somebody who really had a motivation to quit for their own reasons. So she said that she really didn't want to give up smoking until 1981. That was her testimony. Right?
A. Right.
Q. So that's what I mean by not a really serious attempt to remain permanently abstinent until 1981.
You agree?
A. All right. I will accept that definition for the purpose of this question.
Q. Mr. Boerner testified that he didn't think she really wanted to quit smoking on those previous attempts. He described one of them in 1955 or thereabouts as a great

American smoke out day and she only quit for a day. He described another one as quitting to show him that she could. "There, I did it. Now I am going to go back to smoking." Do you recall that?

A. Yes.

Q. In that testimony he said he didn't think Mary Jane Boerner wanted to quit smoking until she did. You saw that?

A. Yes.

Q. They both said that. That's what I mean by the difference between a serious attempt and a non-serious attempt. A serious attempt being an attempt where a person decides that for whatever reasons they no longer want to be a smoker and they want to remain abstinent for the rest of their lives.

A. I take issue then with that definition of serious. To me serious is that they have made a determination to quit irrespective of the pain. And a, quote, less serious attempt would be they will take a certain amount of pain, certain almost of discomfort but not a great deal. I am more comfortable with that.

Q. She made the second decision or the second type of attempt as you described it, she will take a certain amount of withdrawal or pain but not too much --

A. Right.

Q. -- until 1981. Right?
A. Right.
Q. And, Doctor, you do not know why it was that she made that change in her life?
A. Correct.
Q. You do not know why it was that she decided in 1981 that now she was willing to do what was necessary to quit?
A. That's correct.
Q. Again, Doctor, information about smoking and health has not really been strongly correlated with successful cessation?
A. Correct.
Q. You would agree that in the last decade there have been tremendous strides in terms of the publication of anti smoking information?
A. Yes.
Q. There has been a tremendous attempt to change the entire public perception about smoking as a socially acceptable practice?
A. Yes.
Q. And it has been to some degree successful, has it not?
A. Yes.
Q. Tobacco industry has been vilified in the last

ten years, has it not?
A. Yes. And their clever attempts to undercut the affects of public health warnings and even the industry's own warnings, namely, those ideal like scenes in pristine woods, they were eliminated.
Q. So you would agree that the public health community's efforts to combat tobacco has been far more successful in the last ten years than it was before?
A. Yes.
Q. Do you know what the quit rates have been in the last ten years?
A. I don't know how you would define a quit rate.
Q. The percentage of people who have quit versus the percentage of people who smoke. Has quitting increased or decreased in the last ten years?
A. It has increased.
(Whereupon, Defendant's Exhibit 18 was marked.)
MR. SHEFFLER: Q. Let me show what's been marked as Defendants' Exhibit 18. This is from the CDC again from their web site.
You know what the CDC is, Center for Disease Control, and they have published data on public health issues. The first bullet says on Exhibit 18, "Reduction of cigarette smoking occurring since the 1960s is

acknowledged as one of the ten greatest public health achievements of the century."

Do you see that?

A. Yes.

Q. You would agree with that?

A. Right.

Q. "And a per capita consumption decrease of cigarettes from a high of more than 4,345 cigarettes in 1963 to a low of 2,261 in 1998." Do you see that?

A. Yes.

Q. Goes on to talk about the decrease in prevalence rates among adults aged 18 years and older, et cetera.

Look at the sixth bullet point. The sixth says, "Despite tremendous public health strides made in reducing tobacco use, more effort is needed to reduce adult smoking, which has remained virtually unchanged in the 1990's." Do you see that?

A. Yes.

Q. So there was a huge decrease in smoking prevalence.

A. Yes.

Q. Until we get to the 1990's?

A. Yes.

Q. When we have perhaps the most information out there.

A. Yes.
Q. This again is evidence of your statement before that information is not necessarily correlated with cessation?
A. Yes.
Q. And that's not unique to smoking?
A. No.
Q. In fact, information about public health risks does not necessarily translate into lifestyle behaviors, isn't that true?
A. Not necessarily. That's true.
Q. And that does not have to be the result of addition. Correct?
A. Correct.

(Whereupon, Defendant's Exhibit 19 was marked.)

THE WITNESS: Are you planning to ask me why smoking rate reductions have leveled off in the 1990's?
MR. SHEFFLER: Q. Sure. Why have they?
A. I think the trier should know. And since I might have the opportunity to say in trial, you are entitled to know what I think now.
Q. I would like to know if you have an opinion with reasonably degree of medical certainty as to why quit rates have leveled off in the 1990's.

A. Yes, I have an opinion.
Q. Please give me an opinion and then give me the bases for it.
A. There has been nothing new by way of -- there hasn't been that much new by way of public health information. That is, most of the bad stuff has come out already or came out by the 1990's so there are no new shocking revelations. Nothing that would kick the more heavily addicted smokers into the ranks of non smokers.
Second, we may now have gotten the easy cases out of the way of people who are only moderate addicted. Now we are left with the hard core folks.
Thirdly, the efforts to restrict the counter measures of the tobacco industry have also kind of run their course. There has been very little further restrictions on tobacco, advertising and, in fact, if anything, the tobacco companies so-called efforts to help children not start smoking --
Q. Going to move to strike that portion of that testimony.
A. -- have been counterproductive. Where they talk about telling children, now they add "smoking is an adult choice." What better way to get an adolescent to smoke than by telling them that it is an adult choice. We have seen an increase in smoking amongst young people in the

last four, five years and that lowers the averages of the overall reduction rates.

That completes my answer.

Q. Doctor, you had earlier expressed to me the opinion that you did not know whether people were more addicted to smoking percentage wise today or ten years ago, 20 years ago or 30 years ago. Do you now suddenly know that they are more addicted to smoking than they were 10, 20 or 30 years ago?

A. No, I don't.

Q. So you really are speculating when you say that perhaps the more lesser addicted smokers have quit. That's really speculation?

A. That's right. I don't know for a fact that that is so. These are the explanations that make clinical sense to me.

Q. Another explanation that may be advanced is that lifestyle changes are not necessarily the function of knowledge alone?

A. That is true today. It was true seven or eight questions ago, yes.

Q. If counsel would give you the Exhibit 19, Health Progress in the United States, this is an article you have probably seen before?

A. I have.

Q. It is obviously published in the Journal of Medical Association.
A. You want me to read the parts you have in yellow.
Q. Actually, yes. I don't know. Did I highlight anything on the first page?
A. Yes. About three or four paragraphs over the course of the article.
Q. How about the first page.
A. Nothing there.
Q. Just for the record, this article is the result of the Department of Health and Human Services, Lewis Sullivan's release of the results of progress toward the nation's health objectives for 1990. Is that right?
A. Yes.
Q. And they reviewed a number of different health strategies that have been undertaken by the public health authorities, correct?
A. Yes.
Q. On page 2547 of Exhibit 19, under Progress of Preventive Services Objectives. Do you see that?
A. Yes.
Q. It talks about hypertension?
A. Yes.
Q. And if you see the point I highlighted,

"Specifically, data show that from 1979 to 1990, those people who were able to identify risk factors for heart disease increased from 24 percent of adults to 89 percent of adults for high blood pressure." Do you see that?

A. I do.

Q. "32 to 91% for cigarette smoking and from 11 to 90% for cholesterol." Do you see that?

A. Yes.

Q. So first of all, that demonstrates that people were aware of the importance of these matters?

A. Yes.

Q. In fact, they were more aware of cigarette smoking earlier than to a greater extent than anything else?

A. Yes.

Q. Goes on to state that "The only objectives not achieved were those for reducing the prevalence of people who are overweight, an important risk factor for high blood pressure."

A. Right.

Q. So even though they increased the information base, they didn't increase the behavior response?

A. Correct.

Q. And that's not something that's suddenly just been known. People have known this for a long time.

Information is not necessarily correlated with life change?

A. People that have known that without scientific studies is something that is part of communal knowledge, yes.

Q. It is helpful to have it scientifically validated?

A. It can still be true and useful without having been studied in a formal way, yes. We know that.

Q. We know that. We know it is not simply due to addiction?

A. Yes.

Q. If you turn to page 2549. Progress for Health Promotion Objectives.

You see the highlighted portions, "Most impressive are smoking and health results." Wasn't it?

A. Yes.

Q. Goes on to say, "The overall proportion of adults who smoke has fallen by a quarter since 1979, virtually achieving the 25 percent prevalence targeted for 1990."

"In all, more than three-fourths of the 1990 objectives on tobacco use were either achieved or showed notable progress. Those met or exceeded include the targets for increasing public awareness about the specific

health risks of smoking."
A. Yes.
Q. If you go on, though, it talks about obesity. "Dietary and physical activity patterns are associated with five of the ten leading causes of death -- Coronary heart disease, some cancers, stroke, non-insulin dependent diabetes, anellitus and atheroschlerosis.
"Progress was shown for objectives targeting improved public awareness of the relationship between dietary factors and disease, the labeling of feeds, et cetera.
"A significant failure was noted in lowering obesity with the prevalence of people who are overweight unchanged at about 25 percent of adults."
So again there is a disconnect between the information and the lifestyle change?
A. Yes.
Q. Right?
A. Right.
Q. Is that sometimes called a non-compliance effect?
A. Yes.
Q. And we see that not only in obesity but physical activity, the same thing?
A. I suppose it applies here.

Q. It is the same phenomenon. People don't necessarily take information and act upon it?
A. Correct.
Q. And goes on to state on the next page 2550, "Improved awareness of risks and better means for their control did not yield proportional gains in risk-reduction objectives, indicating the difficulty of motivating behavior change through knowledge alone."
And you agree with that?
A. Yes.
Q. And that applies in this case as well?
A. Yes.
Q. "Some of the reasons for those problem changes, problems influenced substantially by personal perspectives that are derivative not just of knowledge, culture, customs, media influences, social situation, housing, employment, cannot be addressed by the public health community alone."
A. Yes.
Q. And again that's true in this case as well?
A. Yes.
Q. So the mere fact that Mrs. Boerner did not change her behavior when confronted with the information about lung cancer and death that could result from her smoking, the mere fact that she did not do that does not

mean that it was the result of her addiction. It could very well have meant she was acting in a non-compliant way when confronted with information about health risks?

A. Yes, that is an alternative explanation.

Q. Do you have any reason to say that that alternative explanation is false?

A. You mean do I have any empirical studies, any scientific proof that it is false, no.

Q. Do you have any clinical proof based upon your discussions with her to say it is false?

A. Yes, I do.

Q. Let the record reflect there was a lengthy pause before that answer.

Go ahead. Give me the rest of the answer as to what that evidence is.

A. She states that she had no access to the public health information that you and I know was prevalent in the community. There is very little in Mrs. Boerner's life, lifestyle, to suggest that she is a liar. She seems to be a pretty straight arrow. So we are faced with something that on its face seems irreconcilable. Here is a woman who is being conscientious, literate person, was subject to increasing quantities of information about a product that she used everyday and she states that it didn't matter or she didn't really see very much of it or

hardly anybody said anybody about nothing. Essentially that was her testimony.

Q. Which we know based upon the fact that her husband and son both told her it could kill her which she did recognize and stated, she did know that?

A. Right. So a little of it must have gotten through to her but most of it by her testimony, and it was under oath, therefore, I can consider it, did not.

This, of course, is characteristic of addictive behavior. It is the denial and selective inattention of addictive behavior and that I think is different than the non-compliance of the individual who won't take his medication or eats fatty foods. I think that's a different phenomenon.

Q. You are familiar with the concept of cognitive dissonance?

A. Yes. That's what we are talking about here.

Q. That concept has been applied to lifestyle behaviors including obesity, has it not?

A. I don't know if it has but I imagine, as I said here, I can conjure up a construct for you.

Q. People will deny that they are obese even though they will be 30 or 40 pounds overweight. They will say I am big boned, I am not that -- I am all muscle. It is not fat.

A. A few people say that. Most obese people are exquisitely sensitive to their obesity but there are a few indeed who will minimize it.

Q. Isn't that a form of dealing with the dissonance that their behavior creates with their knowledge?

A. Yes. But I don't think that's the reason the majority of people remain obese. It is not because they look in the mirror and they rationalize.

Q. But another rationalization could be simply to ignore the information about what obesity has in terms of a lifestyle risk for them?

A. Yes.

Q. And it is true that if you take a survey of the lifestyle risks associated with being a obese and you compare persons who are obese with persons who are not obese, you show that there is a denial of the effect with people who are obese. Do you not?

A. I don't consider myself an expert on all the reasons why obese people continue to remain obese. But it seems to me that to go from obese to proper weight requires tremendous -- to give up something to which they had become very attached. And it is a very painful process. There is not the profound, clear connection between obesity and health catastrophes that there now is for smoking.

Q. Have you read the recent Surgeon General's report on obesity, 300,000 deaths a year?
A. It is bad news but I don't think it is out in the community to the extent that it is about smoking. I think everybody now knows smoking will kill you. Most fat people don't know that obesity will kill you. They may not for the next five or ten years.
Q. Or they may deny that it is?
A. They will continue to deny because that is a human process.
Q. And it is a way of dealing with dissonance?
A. It is not unique to addicted people.
Q. And, Doctor, going back then to saying the fact that Mrs. Boerner didn't know or didn't appreciate what she obviously had been told doesn't necessarily mean that it wasn't a fact that she was just trying to deal with, the dissonance created by the information?
A. That's true. I cannot definitively rule out the alternative explanation.
MR. SHEFFLER: Can you let us caucus outside for about two minutes?
THE WITNESS: I would be delighted if you would.
(Recess taken.)
MR. SHEFFLER: Dr. Blinder, we have marked as 13A and 13B. The deposition of Mr. Scoggins is 13B. And

Mr. Boerner is 13A, second volume, with your notations and I guess dog eared pages to reflect where you have something of note.

Would you just confirm that, please?

A. Yes, that is correct.

MR. SHEFFLER: With that, I think we have no further questions at this time. They are going to be attachments to your deposition.

(Whereupon, at the hour of 1:35 o'clock p.m., the deposition was concluded.)

_____

MARTIN BLINDER, M.D.

STATE OF CALIFORNIA)
) ss.
COUNTY OF MARIN)

I, ANASTASIA ROCKWELL, a Certified Shorthand Reporter of the State of Californian, duly authorized to administer oaths pursuant to Section 8211 of the California Code of Civil Procedure, do hereby certify that MARTIN BLINDER, M.D., a witness in the foregoing deposition, was by me duly sworn to testify the truth, the whole truth and nothing but the truth in the within-entitled cause; that said testimony of said witness was reported by me, a disinterested person, and was thereafter produced under my direction in typewriting.

I further certify that I am not of counsel or attorney for either or any of the parties in the foregoing deposition and caption named, nor in any way interested in the outcome of the cause named in said caption.

Dated the 2nd day of January, 2000.

_____

ANASTASIA ROCKWELL
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January 2, 2000
Dr. Martin Blinder
130 Melville
San Anselmo, California
Re: Boerner vs. Brown & Williamson
Dear Dr. Blinder,
The original transcript of your deposition in the above-entitled action, taken on December 13, 1999, is available at our office. If you wish to make arrangements to read, correct and sign the transcript, please telephone me before March 15, 2000.
Sincerely,
Kathleen L. Goldstein
Office Manager
cc: Original of deposition
Bruce G. Sheffler, Attorney at Law
Frank C. Woodside, Attorney at Law
James Gerald Schulze, Attorney at Law
Reported by: ANASTASIA ROCKWELL, CSR No. 4385 (CA)